Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SHANNON MEDICAL CENTER
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
EMPLOYERS INSURANCE OF WAUSAU MUTUAL CO

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-12-0457-01

MFDR Date Received
October 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "When Dr. Sanchez's office scheduled this surgery they gave the hospital Medicare as the insurance. Apparently, on Friday 10/15/10, the Doctors office found out about the workman's compensation insurance and called the adjuster Sherrie Ripen. Sherrie was out that day so she didn't call back until Monday, 10/18/10–the day the procedure was scheduled. She told the Doctors office to get an auth–which they called in for immediately. The auth was approved for 10/19/10 to 11/19/10–however the procedure was done on 10/18/10. The patient was already in the hospital and prepped for the procedure while all this was going on. The procedure was obviously medically necessary and an auth was given–but the review company didn't date it until the next day–10/19/10. The insurance denied this claim for no pre-auth because even though the Doctors office requested 10/18/10 as the DOS, the pre auth company started the auth 10/19/10. The adjustor has refused to override the denial. I have verified with the Doctors office that they had no knowledge of workman's compensation insurance prior to 10/15/10."

Amount in Dispute: $49,621.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is a lack of preauthorization for the DOS. The provider did not submit documentation as required by Rule 133.307(c)(2)(D) establishing that it obtained pre-authorization from the carrier."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2010	Outpatient Hospital Services	$49,621.19	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Precertification/authorization/notification absent. $0.00
   - 851-000 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION. UMD RECOMMENDS $0.00

Issues

1. Is the insurance carrier's denial reason supported?

Findings

1. The insurance carrier denied payment for the disputed services with reason codes 197 – "Precertification/ authorization/notification absent. $0.00"and 851-000 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION. UMD RECOMMENDS $0.00." Per 28 Texas Administrative Code §134.600(c) "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions); (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Review of the submitted information finds insufficient documentation to support the occurrence of a medical emergency, or that preauthorization was approved prior to providing the disputed health care. Consequently, the insurance carrier's denial reason is supported. Reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	November 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.